**ANN ARBOR PUBLIC SCHOOLS**
**Other Eligible Adult Benefits Fact Sheet**
**Medical/Prescription/Dental/Vision Coverage**

Beginning July 1, 2009, an Ann Arbor Public School District ("District") employee may enroll an adult individual ("Other Eligible Adult") for benefit coverage under one of the District's medical/prescription/dental/vision plans ("Plan") subject to the following:

**Conditions**

1. The employee is eligible for District benefits and participates in a District offered Plan;

2. The Other Eligible Adult satisfies eligibility standards required by or applicable to the Plan;

3. The employee and the Other Eligible Adult comply with any conditions required by or applicable to the Plan;

4. The Plan accepts the Other Eligible Adult as a participant;

5. The enrollment of an Other Eligible Adult for benefit coverage under one of the District's Plans is contingent on the employee and/or Other Eligible Adult submitting documentation establishing conditions 6(a-d) and 7(a-e), below, to the satisfaction of the District, and providing any other documentation requested by the District.

6. The Other Eligible Adult:

   a) Is 26 years of age or older; and

   b) Is not the employee's "dependent" as defined by the Internal Revenue Service; and

   c) Is not covered by any other insurance plan; and

   d) Is not an undocumented immigrant.

7. The employee and the Other Eligible Adult:

   a) Reside together and have done so for 18 continuous months prior to the Other Eligible Adult's enrollment in the Plan; and

   b) Are not married to any other party; and

   c) Are not related by blood (child, grandchild, parent, grandparent, sibling, niece, nephew, aunt, uncle, cousin) or marriage; and

   d) Are not in a landlord, tenant, or boarder relationship; and

e) Are financially interdependent. Financial interdependence may be established by submission of proof of joint bank account, joint home ownership or other documented proof.

**Dependent Children of Other Individual**

In addition to coverage for an Other Eligible Adult, an employee may elect coverage for the eligible child(ren) of an Other Eligible Adult, contingent on the Other Eligible Adult submitting documentation establishing dependent status, to the satisfaction of the District. The dependent children are eligible for coverage through the end of the month they:

- Live primarily with the employee, including periods when living temporarily away from home attending school;
- Are eligible to be claimed as a dependent on the employee's or the Other Eligible Adult's most recent income tax return; and
- Meet eligibility criteria established by the applicable carrier.

The dependent children of an Other Eligible Adult are not eligible for coverage through the District as an employee; and are not eligible for coverage if they are covered through the District as a dependent on another District employee's coverage.

**Cost of Other Eligible Adult Benefits**

The insurance premium rates and District and employee contributions, when coverage is provided to an Other Eligible Adult, are identical to those for two-persons or families (i.e., the two-person rate and contribution would apply if the coverage changes from single to two-person, the family rate and contribution would apply if the coverage changes from single or two-persons to family).

**Taxation of Other Eligible Adult Benefits**

When an employee enrolls an Other Eligible Adult (or the Other Eligible Adult's dependent child[ren]) in a District sponsored health plan, the District's contribution toward the additional coverage will be included in the employee's gross income for state and federal income taxes as well as for FICA (Social Security and Medicare) taxes withheld from the employee's paycheck. On the employee's earnings statement, this taxable benefit will be reflected under "Other Taxable" and will be added to the employee's taxable gross income.

**Confidentiality**

The District will keep records containing information on Other Eligible Adults confidential to the extent permitted by law.

**Enrollment**

An Other Eligible Adult may be added at the following times:

Annual Open Enrollment Period: An annual Open Enrollment period is held, usually in May, during which benefits elections may be changed, including adding or deleting persons covered under benefits. Any election changes made during Open Enrollment are effective July 1, with the start of the new plan year, unless a later effective date is determined by the Plan.

New Hire: Newly hired employees may elect coverage for themselves and an Other Eligible Adult providing District and Plan eligibility requirements and conditions are met. To enroll, the employee will be required to select the appropriate coverage level on the election form and list the Other Eligible Adult on the cover sheet.

Eligibility event during Plan year: Once the criteria defining eligibility has been met, the employee will have only 30 days to add an Other Eligible Adult to his/her coverage. If the Other Eligible Adult were to lose coverage elsewhere, the employee would have only 30 days to add the Other Eligible Adult to his/her coverage.

To request the addition of an Other Eligible Adult, whether during the open enrollment period, as a new hire, or following an eligibility event, the employee must:

1. Complete an Enrollment Application form.
2. Sign an Affidavit Relating to Enrollment of Other Eligible Adult.
3. Submit an Affidavit from the Other Eligible Adult.
4. Read and acknowledge receipt of the District's Other Eligible Adult Fact Sheet.
5. Return the completed Enrollment Application Form and Affidavits to the Fringe Benefit office or directly to the insurance carrier – as directed.

When enrollment follows the occurrence of an eligibility event, all forms MUST be returned within 30 days of the event causing the addition of the Other Eligible Adult.

**If the required enrollment materials are not completed and returned within 30 days of the event, the employee may not add an Other Eligible Adult until open enrollment.**

**Employee Notice Obligations – Change in Other Eligible Adult Status or Status of Other Eligible Adult Dependent Child[ren]**

The employee must notify the District's Fringe Benefit Office and complete all applicable District and Plan documents, including Notification of Change in Other Eligible Adult Status or status of Other Eligible Adult's Dependent Child[ren] within thirty (30) days of any of the following events:

- Any of the Other Eligible Adult eligibility Conditions set out in 6(b)-(d) and/or 7(a)-(e) above, are no longer true.

- The child[ren] of the Other Eligible Adult no longer qualify(ies) as a dependent child, and/or no longer meet(s) eligibility criteria established by the applicable carrier.

**Any false statement made by an employee, the failure of an employee to notify the District that any of the conditions set out in 6(b)-(d) and/or 7(a)-(e) are no longer true, or the failure of any employee to notify the District that the child[ren] of the Other Eligible Adult no longer qualify(ies) as a dependent child and/or no longer meet(s) eligibility criteria established by the applicable carrier, is cause for disciplinary action up to add including discharge and liability for losses (i.e., claims paid according to Plan specifications) incurred and the District's costs and attorneys fees, if any, related to collection of said losses.**

**Cancellation of Coverage**

Coverage of the Other Eligible Adult will be canceled at the end of any month in which (1) the employee is no longer eligible for District Benefits, (2) any of the Conditions set forth in 6(b)-(d) and/or 7(a)-(e) above, are no longer true, (3) the District is notified by the Plan that the coverage will no longer be provided, either generally or to a specific Other Eligible Adult, (4) coverage conflicts with the terms of an applicable collective bargaining agreement, or (5) the District cancels coverage to Other Eligible Adults when it deems cancellation is necessary in order to comply with state or federal laws, or for other reasons determined at the District's discretion.

The Employee and Other Eligible Adult will be responsible for charges for services or benefits provided for under the Plan after the Other Eligible Adult ceases to be eligible for coverage.

**Subsequent Other Eligible Adult**

If the Employee deletes his or her Other Eligible Adult from coverage, neither a new Other Eligible Adult nor a previous Other Eligible Adult can be added until all of the eligibility standards are met and 18 months have elapsed from the date of deletion of the previous Other Eligible Adult.

**COBRA**

There are no rights to COBRA continuation for an Other Eligible Adult, or the Other Eligible Adult's dependent child[ren].

**Effective Date**

The effective date of coverage for an Other Eligible Adult shall be determined by the Plan.

**Forms**

All forms can be obtained from District Fringe Benefits, 2555 S. State St., Balas I.

**Questions**

Questions should be directed to Fringe Benefits at (734) 994-1666.

**The District retains the right to modify terms or conditions of coverage or to cancel coverage to the Other Eligible Adult upon thirty (30) days notice, if deemed necessary in order to comply with state or federal laws, or for other reasons determined at the District's discretion.**

I acknowledge receipt of the Ann Arbor Public School's Other Eligible Adult Benefits Fact Sheet.

_____ _____

[Print Name]

Employee Signature Date

_____ _____

[Print Name]

Other Eligible Adult Signature Date

_____ _____

Fringe Benefits Representative verification Date

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**ANN ARBOR PUBLIC SCHOOLS**
**Affidavit of Employee**

This Affidavit is submitted with respect to my application to add _____ as an Other Eligible Adult for benefit coverage under the District's _____ Plan.

I, _____, hereby affirm the following:

1. _____ is not my dependant as defined by the Internal Revenue Service.

2. I am not _____'s dependant as defined by the Internal Revenue Service.

3. _____ and I

   A. currently reside together and have done so for 18 continuous months,

   B. are not married to any other party,

   C. are not related by blood (child, grandchild, parent, grandparent, sibling, niece, nephew, aunt, uncle, cousin) or marriage,

   D. are not in a landlord, tenant or boarder relationship, and

   E. are financially interdependent.

4. Coverage provided to _____ as an Other Eligible Adult, and his/her dependent child[ren], if applicable, will cease in the event:

   A. _____ obtains other insurance coverage,

   B. _____ and I

      i) enter into a landlord, tenant or boarder relationship,

      ii) no longer reside together,

      iii) marry each other or either of us marries someone else, or

      iv) are no longer financially interdependent; or

   C. I am no longer eligible for coverage under the Plan.

5. Coverage provided to _____'s dependent child[ren] will cease either when he/she no longer claims him/her as a dependent for income tax purposes he/she no longer primarily lives with me and _____, excluding periods in which he/she is temporarily living elsewhere while attending school, or he/she no longer meets eligibility criteria established by the applicable carrier.

6. I am required to and will notify the District's Fringe Benefits Office, 2555 S. State St., Ann Arbor MI 48104, (734) 994-1666, Fax# (734) 994-2020, and

complete any applicable District or Plan documents within 30 days of any event described in #4.A, 4.B (i)-(iv) and 5, above.

7. Any false statement made by me or my failure to notify the District as provided for in #6 above, will subject me to liability for losses (i.e., claims paid according to Plan specifications) incurred by the District on behalf of _____, and the District's costs and attorneys fees, if any, related to collection of said losses.

8. As a condition of coverage being provided to _____, I am required to comply with any conditions required by or applicable to the applicable insurance plan.

9. I understand that the effective date of coverage for _____ is determined according to the terms of the Plan.

10. I understand that I may not file another Affidavit for Enrollment for another Other Eligible Adult to establish a new Other Eligible Adult until at least 18 months after termination of coverage for a previous Other Eligible Adult.

11. I understand and agree that enrollment of _____ for benefit coverage is contingent on _____ and/or me submitting documentation establishing conditions 6(a-d) and 7(a-e) in the Ann Arbor Public Schools Other Eligible Adult Fact Sheet ("Fact Sheet") to the satisfaction of the District, and providing any other documentation requested by the District, or its agents.

12. I understand and agree that enrollment for benefit coverage of _____'s child[ren] is contingent on him/her submitting documentation establishing dependent status, to the satisfaction of the District, providing any other documentation requested by the District, or its agents, and meeting eligibility criteria established by the applicable carrier.

13. **I have received a copy of the District's Fact Sheet. I understand the District retains the right to modify the terms or conditions of coverage or to cancel coverage to the Other Eligible Adult and/or his/her dependent child[ren] upon thirty (30) days notice, if deemed necessary in order to comply with state or federal laws, or for other reasons determined at the District's discretion.**

_____ _____

Print Employee Name Date

_____

Employee Signature

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# ANN ARBOR PUBLIC SCHOOLS

## Affidavit of Other Eligible Adult

This affidavit is submitted with respect to an application by _____ to add me as an Other Eligible Adult for benefit coverage under the District's _____ Plan.

I, _____, hereby affirm the following:

1. I am 26 years old or older.
2. _____ is not my dependant as defined by the Internal Revenue Service,
3. I am not
   - A. _____'s dependant as defined by the Internal Revenue Service,
   - B. covered by another insurance plan, or
   - C. an undocumented immigrant.
4. _____ and I
   - A. currently reside together and have done so for 18 continuous months,
   - B. are not married to any other party,
   - C. are not related by blood (child, grandchild, parent, grandparent, sibling, niece, nephew, aunt, uncle, cousin) or marriage,
   - D. are not in a landlord, tenant or boarder relationship, and
   - E. are financially interdependent.
5. I have claimed _____ on my most recent income tax return and he/she lives primarily with me and _____, excluding periods in which he/she is temporarily living elsewhere while attending school.
6. Coverage provided to me as an Other Eligible Adult, and my dependent child[ren], if applicable, will cease in the event:
   - A. I obtain other insurance coverage,
   - B. _____ and I
     - i) enter into a landlord, tenant or boarder relationship,
     - ii) no longer reside together,
     - iii) marry each other or either of us marries someone else,
     - iv) are no longer financially interdependent; or
   - C. _____ is no longer eligible for coverage under the Plan.

7. Coverage provided to _____ [dependent child(ren)] will cease either when I no longer claim him/her as a dependent for income tax purposes, he/she no longer primarily lives with me and _____, excluding periods in which he/she is temporarily living elsewhere while attending school, or he/she no longer meets eligibility criteria established by the applicable carrier.

8. I am required to, and will notify the District's Fringe Benefits Office 2555 S. State St, Ann Arbor, MI 48104, (734) 994-1666, Fax# (734) 994-2020, and complete any applicable District or Plan documents within 30 days of any event described in 6.A, 6. B (i)-(iv) or 7, above.

9. Any false statement made by me or my failure to notify the District as provided for in #8 above, will subject me to liability for losses (i.e., claims paid according to Plan specifications) incurred by the District on my behalf, and the District's costs and attorneys fees, if any, related to collection of said losses.

10. As a condition of being provided with coverage, I am required to comply with any conditions required by or applicable to the applicable insurance plan.

11. I understand that there are no rights to COBRA continuation coverage for myself or my dependents in the event coverage terminates.

12. I understand that the effective date of coverage is determined according to the terms of the Plan.

13. I understand and agree that my enrollment for benefit coverage is contingent on _____ and/or me submitting documentation establishing conditions 6(a-d) and 7(a-e) in the Ann Arbor Public Schools Other Eligible Adult Fact Sheet ("Fact Sheet") to the satisfaction of the District, or its agents, and providing any other documentation requested by the District.

14. I understand and agree that enrollment for benefit coverage of my child[ren] is contingent on my submitting documentation establishing dependent status, to the satisfaction of the District, providing any other documentation requested by the District, or its agents, and meeting eligibility criteria established by the applicable carrier.

15. **I have received a copy of the District's Fact Sheet. I understand the District retains the right to modify the terms or conditions of coverage or to cancel my coverage and the coverage of my dependent child[ren] upon thirty (30) days notice, if deemed necessary in order to comply with state or federal laws, or for other reasons determined at the District's discretion.**

_____ _____

Print Other Eligible Adult Name Date

_____

Other Eligible Adult Signature

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